Bozeman (N.)

Retroversion in relation to Lacerations of the Cervix Uteri, etc.

BY

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THE MECHANISM OF RETROVERSION AND PROLAPSUS OF THE UTERUS CONSIDERED IN RELATION TO THE SIMPLE LACERATIONS OF THE CERVIX UTERI AND THEIR TREATMENT BY BLOODY OPERATIONS.

BY NATHAN BOZEMAN, M. D.,

New York.

WITHIN the last few years the subject of simple lacerations of the cervix uteri and their treatment by bloody operations has received much attention both in this country and in Europe. This is due partly to an increasing sense of its importance, but mainly, perhaps, to an able paper entitled "Laceration of the Cervix Uteri as a Frequent and unrecognized Cause of Disease" read before the Medical Society of the County of New York by Dr. T. A. Emmet, September 18, 1874, and published in the "American Journal of Obstetrics" for November of the same year.

In a second paper, published in the "American Practitioner" for January, 1877, Dr. Emmet presented his views upon this subject in the form of answers to certain objections which had been made relating to the value of the operative procedure, rather than in support of former claims by the addition of new facts.

The views advanced by Dr. Emmet in the papers referred to, and, so far as I know, entertained by him at the present time, may be summarized in the following nine propositions: —

First. When the laceration of the cervix uteri extends to or beyond the vaginal junction on one or both sides, eversion of the lips and dropping down of the body of the

organ — more marked, of course, in the bilateral form — are the natural consequences.

Second. The changes in form, relationship, and function of the cervix, under these circumstances, are due to the facts that soon after labor the posterior lip catches on the rectal wall of the vagina and the anterior lip extends downwards in the axis of the vagina.

Third. The irritation of the lacerated surfaces at the angles of the injury, or the erosions upon the everted lips, leads to the arrest of involution of the uterus and, indirectly, to retroversion.

Fourth. The increased weight of the uterus sooner or later flattens the everted lips of the cervix against the rectal wall of the vagina, and thus conduces to the effacement of all traces of the original laceration.

Fifth. The presenting cervical orifice is sometimes deceptive with regard to the true axis of the canal as well as the dimensions of the cervix itself. The size generally appears to be increased because of the dragging upon the cervix and the higher reflexion of the vaginal walls.

Sixth. When lacerations of the cervix are allowed to remain without treatment the mucous follicles of the hypertrophied and everted lining membrane of the cervical canal are liable to take on "cystic degeneration," and finally rupture and disappear.

Seventh. Rupture of the perineum frequently accompanies laceration of the cervix and, when present, always increases the gravity of the latter, because it further weakens the already overburdened vaginal walls.

Eighth. The preparatory treatment consists principally in the use of large vaginal injections, of warm water (100° F.), night and morning, elastic and distended ring pessaries of suitable size, tannin in glycerine applied to the vaginal walls once a day, and subsulphate of iron applied once a week. These means must be continued from one to three months or until all inflammatory action has subsided.

Ninth. If, after the bloody operations upon the lacerated cervix, the prolapsed vaginal wall or walls, and upon

the perineum, there still appears to be need of the pessary, it must be reinserted and continued in use until the cure is completed.

It is not my purpose to enter upon a discussion of the views entertained by Dr. Emmet, but simply to state, in as brief a manner as possible, my own views concerning certain points touched upon by him, and with reference to which I am not entirely satisfied. Suffice it to say, he gives a very good reflex of the opinions entertained by a large number of gynecologists at the present time, and his views, in the light of his extended experience and study of the subject, are certainly entitled to great consideration.

In the first place, I will remark that every variety of uterine displacement is as much a problem in mechanics as are the various forms of simple labor. A proper explanation of the latter gives a fair view of the former, since, with but slight reservation, the general laws which govern the one also govern the other. The simple difference is, that on the one hand there is a physiological transit of a well-formed fetus of proportionate size into and out of a normal pelvis in consequence of greatly increased physical forces; while on the other there is a pathological transit of a morbid uterus, having a disproportionate size, out of a normal pelvis, in consequence of greatly diminished physical forces.

The peculiar province of the obstetrician is to study these laws from a physiological standpoint, while the gynecologist studies them from a pathological point of view.

Presuming that the natural forces are equally balanced and regular in their action upon the healthy unimpregnated uterus, it is important to explain precisely what is meant by these forces, and in what particulars the forces developed as the result of disease differ from them.

The natural forces may be properly divided into two classes: 1. The expulsive forces. 2. The counteracting forces.

The *expulsive forces* are those which arise from the descent of the diaphragm, as in inspiration, and the contraction of the abdominal muscles, as in defecation. The forces

developed by the contraction of these muscles act upon the uterus though the superincumbent abdominal organs, and in a line corresponding somewhat to the axes of the pelvic cavity. They are also regular and constant in their operation.

The *counteracting forces* are: (1) Those which arise from the vesico-vaginal and the recto-vaginal walls; (2) from the sacro-uterine ligaments; (3) from the broad and round ligaments; (4) from the pelvic peritoneum and subperitoneal areolar tissue; and (5) from the perineum.

These forces are also regular and constant in their operation, and in health effectually antagonize the action of the expulsive forces. It is only when they become partially or wholly impaired by disease that they lose their antagonizing power. When that power is diminished, the uterus, whether it be diseased or not, begins to descend in consequence of the constant and regular action of the unimpaired expulsive forces.

The morbid forces, properly speaking, are acquired, and I shall therefore designate them as the *acquired forces*.

These acquired forces are developed in the pelvis, in a greater or less degree, after each and every parturient act, and are, therefore, in themselves irregular and only incidentally operative. They are coöperative, in the highest degree, with the expulsive forces whenever the antagonism of the counteracting forces is impaired or lost.

The direction in which the acquired or morbid forces operate, varies according to the position of the uterus in the different stages of displacement. According to their action in the different stages they may be designated as follows: (1) The determining force; (2) The supplementing force; and (3) The extruding force. The first and the third have their origin in the bladder, and are developed both at the beginning and at the close of the process of retroversion and of prolapsus.

The second resides in the rectum.

Let us suppose in the first stage of displacement present a few days or weeks after a tedious or difficult labor, when

there is a traumatic condition of the interior of the uterus, with increased weight and size, that the bladder is greatly distended, the direction in which the determining force operates is at a somewhat obtuse angle with reference to the long axis of the uterus, but in a general way tends to carry the organ backwards and downwards as the woman lies upon her back.

In the second stage, when the uterus has reached a horizontal position and is compressing the rectum, the supplementing force, developed by the accumulation of feces above, acts nearly parallel to the long axis of the uterus and carries it downwards and forwards. This force is coöperative in the highest degree with the expulsive forces.

In the third stage, when the uterus, in a strongly retroverted position, reaches the vaginal orifice, the extruding force, developed by the dropping down of the base of the bladder, and a greater or less accumulation of urine, operates almost at a right angle with the long axis of the uterus and carries it downwards and forwards against the perineum, finally beyond it, as in complete procidentia.

If it be true, then, that the counteracting forces residing in the parts enumerated may be so impaired either by injury or by disease, as to give preponderance to the expulsive forces, and thus permit a normal uterus to become retroverted or prolapsed, a condition sometimes seen in practice, it makes the mechanism of the process much clearer when displacement occurs in a uterus that is the seat of chronic inflammation affecting either the substance or its lining membrane. For the chronic inflammation increases the weight and size of the organ, and the expulsive are supplemented by the acquired or morbid forces.

Laceration of the cervix may contribute to the acquired or morbid forces, but, independent of endometritis and subinvolution, so slight and unimportant an injury can hardly be expected to lead to such serious derangement of the counteracting forces.

This little accident often forms an annoying complication of retroversion, and so may laceration of the perineum.

In the one case, however, the injury is of no particular consequence, since no counteracting force is impaired by it, but in the other it is of serious import, because, with removal of the perineum, an important counteracting force is at once lost. Such an important loss gives rise to a preponderance of the expulsive forces, and sooner or later is followed by descent of the uterus, and breaking down of the vaginal walls.

Again, stretching of the sacro-uterine ligaments produced by the descent of the child into the pelvic cavity, while the cervix remains only partially dilated, might prove to be of no special consequence under proper care, and the observance of the recumbent posture for a sufficient length of time. But, being the seat of a most important counteracting force, the slightest imprudence in assuming the erect posture would almost inevitably result in a descent of the uterus, and an increase of the preponderance of the expulsive forces.

It is the impairment of this factor in the system of counteracting forces that, perhaps, more than all others combined, leads to retroversion and prolapsus of the uterus, especially among the poorer classes, who are compelled to leave the recumbent posture before the damaged structure has had time to regain its natural integrity.

It is in connection with this seemingly small injury, and in this class of cases, I think, that the worst forms of eversion and erosion of the lips of a lacerated cervix are found, and doubtless the condition is aggravated by the accompanying endometritis and sub-involution, a want of proper cleanliness, and a too early indulgence in the marital rights. Endometritis and sub-involution, I believe, are almost always, if not always, present under such circumstances. The erosions usually found upon the everted lips, or at the angles of the infra-vaginal tear, when present, are referable to the acridness of the uterine discharge, and to other causes above mentioned.

With the stretching or elongation of these ligaments, the weight of the already enlarged uterus falls upon the ante-

rior and posterior vaginal walls, and increases the traction upon the vaginal attachments to the sides of the cervix uteri. In this manner inversion of the vagina is commenced, and, finally, there is more or less eversion of the cervix, whether notched on one or both sides, or not at all.

These changes in the form of the cervix and the vagina are doubtless effected through the combined action of the expulsive and acquired forces. They are seen to the best advantage when the uterus has reached its horizontal position upon the rectum, and before it has come under the influence of the supplementing force.

The uterus, having reached this stage of retroversion by the resolution of forces, it is only the posterior lip of the cervix which can be supposed to have impinged against the rectal wall, and this again only in a diminishing degree, until it is entirely relieved from such pressure and friction.

It is in this manner and in this stage of displacement that the peculiar elongation of the anterior lip of the cervix in the direction of the axis of the vagina takes place, so correctly pointed out by Dr. Emmet, which does not occur in the stage in which the organ is in a horizontal position upon the rectum, when both lips of the cervix are free from mechanical pressure The eversion or effacement of both lips takes place only when all pressure has been removed from them, and the entire organ is under the combined influence of the expulsive and supplementing forces which carry it downwards and forwards to the vaginal orifice.

It is by these forces that the sides of the organ are now compressed, and its size often diminished. At the same time stretching of the broad and round ligaments is known to take place. Independent of endometritis and sub-involution the uterus may now glide down until the cervix reaches the vaginal orifice, when the extruding and the expulsive forces become united. By the combined action of these two forces the cervix uteri is compressed laterally and the organ is driven downwards and forwards against the perineum. Finally, the resistance offered by the perineum is overcome, and the entire organ, often of its normal size, is forced from

the body. In the last steps of the descent every vestige of resistance offered by the vesico-vaginal and recto-vaginal walls is overcome. The vagina, in short, is inverted. The broad and round ligaments, the perineum, the pelvic peritoneum, and pelvic areolar tissue, the other counteracting forces, are then put upon their greatest strain, and the condition known as *complete procidentia uteri* is present.

While there is a joint action of the expulsive and the supplementing forces the broad ligaments may not yield at all, or only to a slight extent, and the further descent of the body of the uterus be prevented.

In that event the same forces will drive the fundus further down upon the rectum, and thus cause retroflexion. One or both ovaries often become involved in the process, are crowded against the rectum, and in that manner the most intense suffering is produced.

The cervix, under these circumstances may, in form and size, remain stationary, or undergo hypertrophy, and attain a length of two or more inches, as I have often seen. In this latter condition there is little or no prolapsus of the base of the bladder, consequently little or no development of the extruding force.

Another change, which I have very often seen under these circumstances, and one which is by far the most grave, is the stretching of the lower part of the body of the uterus. At the same time there is increase of the expulsive forces, perhaps, induced by the imprisonment of the ovaries.

As a result of all this, the bladder is dragged down to the vaginal orifice with the cervix alone, and in the usual way the extruding force is developed. The extruding force then coöperating with the expulsive forces sooner or later pushes the perineum back, and drives the cervix out of the body. In this manner we have *incomplete procidentia uteri* produced.

In this condition the uterus stands astride the perineum, with the concavity of its curve presenting backwards, and measuring in its entire length from four to seven inches or more.

Treatment. — The treatment of all forms of uterine displacement, properly speaking, falls within the broad domain of surgery. It is conveniently divided into three varieties: (1) Constitutional; (2) Local; (3) Mechanical.

The gynecologist who resorts to all of these methods of treatment, will, I believe, find his way to success much easier than he who contents himself with the use only of one or the other of the measures named.

When I say that the treatment of uterine displacements comes within the broad domain of surgery, I do not mean that the knife is to be used indiscriminately, and bloody operations performed for every uterine trouble which may present itself, but refer, rather, to an intelligent appreciation and application of the true principles of surgery based upon sound pathology, therapeutics, and physics, such as are applied to the treatment of diseases and accidents in general. It is true, that it may be occasionally necessary to perform bloody operations, but from my stand-point they should be made the exception, and not the rule.

When the perineum is ruptured, either in labor or otherwise, it becomes necessary perhaps to repair it by a bloody operation. It should be restored, if possible, because it is an important counteracting force. It should be restored with the view of restoring the lost functions of the rectum, and of promoting immediately or prospectively the resiliency of the vesico-vaginal and recto-vaginal walls, as well as other structures situated higher up in the pelvic cavity and the seat of equally valuable forces. Too much importance, therefore, cannot be attached to this bloody operation. Even when the perineum is only partially lacerated, or its resistance has been overcome by the successive yielding of other uterine supports, as in complete and incomplete procidentia, a bloody operation becomes a necessity. Not so much however, to prevent the expulsion of the uterus as to increase the breadth and strength of the base of support. The *point d'appui* thus improved and strengthened, better receives and retains the mechanical support afterwards necessary to elevate the uterus, and increase the resiliency of

the structures which are the seat of all the other counteracting forces, but especially the weakened and broken-down walls of the vagina.

Bloody operations have been performed upon the anterior and the posterior walls of the vagina and for nearly the same purpose as when performed upon the perineum. Such operations are sometimes made in connection with that for restoration of the perineum; more frequently they precede the latter, because of the greater facility with which the parts can then be reached.

Whether such bloody operations upon the vaginal walls possess any intrinsic value, is by no means settled. With reference to simple, uncomplicated cystocele and rectocele, the operation is somewhat promising; yet I think statistics do not establish the value which is claimed for it by some operators. As a means of giving support to the uterus, even when performed in connection with perineorrhaphia, it possesses only temporary utility, and for two reasons:—

First, Because there is a most complete loss of the counteracting forces residing in the sacro-uterine, broad, and round ligaments, with increased preponderance of the abdominal or the expulsive forces.

Second, Because the one or two cicatricial lines formed have a longitudinal direction and consequently are not well adapted for giving support to the uterus under the adverse influences just mentioned. The modification of this operation proposed by Professor Le Fort of Paris, in cases of procidentia uteri, seems to promise better results than have heretofore been obtained. For securing a better mechanical adaptation of the vaginal walls his modification is entitled to consideration.

He proposes to denude both walls of the vagina along the median line and then unite the raw surfaces with sutures. In that manner he forms a conjoined partition which divides the vagina into two equal parts.

I have not yet resorted to this somewhat novel procedure, but I confess I am rather favorably impressed with the principle. The greatest objection, of course, to the pro-

cedure is the partial interference with the sexual and generative functions. Every one who has had any experience in the treatment of atresia of the vagina knows how effective that condition is in preventing prolapsus of the uterus. It matters not whether the atresia has a transverse, oblique, or longitudinal direction, and it is undoubtedly upon the same principle that the modification proposed by Professor Le Fort is to operate.

As we have already remarked, Dr. Emmet recommends the bloody operation for unilateral or bilateral laceration of the cervix as a means of relieving retroversion and prolapsus of the uterus. He claims that, by freshening the edges of the lacerated parts and then uniting them with sutures, the uterus as a whole is elevated and in that manner the operation contributes to the removal of the subinvolution and perhaps the antecedent endometritis, although he does not mention the last factor. According to his own statement he has performed this operation several hundred times, and claims a large share of success. But in estimating the success which Dr. E. attaches to the operation certain prominent facts must be taken into consideration. First, The course of preparatory treatment to which he subjects his patients, varying from one to three months in length, before the bloody operation in question is performed either alone or in connection with perineorrhaphy and kolporrhaphy. Second, The after-treatment, which consists in the use of a suitable pessary, if there remain, on the part of the uterus, a tendency to descend, until the cure is completed.

Now when it is remembered that the healthy cervix uteri projects into the vagina only four or five lines and that in this portion no special counteracting force resides, it is difficult to understand by what mechanical law the body of the organ, when it is in a condition of subinvolution and deprived to a greater or less extent of its ligamentous support and at the same time is under the full influence of the preponderating expulsive forces, can be elevated by the mere approximation and union of the divided lips.

When the operation is performed in the most skillful manner, and is followed by the most complete surgical success, certainly it does not restore or improve to any appreciable extent a single supra-vaginal counteracting force.

While the operation may be necessary under certain circumstances, it has always seemed to me that in the largest proportion of cases, about the same results can be obtained by simply leeching and disgorging the congested parts, together with the preparatory and the after-treatment, as are obtained by freshening the parts and the use of sutures.

In other words, when the parts fail to unite, as I have often seen, the patient derives about the same amount of benefit she would have received had the surgical operation been a complete success. Certainly this is true of the patulous os resulting from a long-standing endometritis, and upon which some of Dr. Emmet's most enthusiastic followers do not hesitate to operate in the belief that by so doing they relieve the antecedent morbid condition of the lining membrane of the cavity of the organ. Where is the surgeon, properly so called, to be found who would deliberately sew up or contract the outlet of a pelvic abscess or a fistulous tract in the rectum, with the avowed purpose of curing or even relieving the antecedent pathological condition of those natural exits? Yet the one procedure is not more irrational or reprehensible than the other. Herein is seen the abuse of the operation. Instances of such abuse have fallen under my own observation, and, I dare say, that of other observers.

With regard to the unilateral laceration which sometimes extends beyond the vaginal attachment, there is usually little or no dropping down of the uterus, even under the influence of the preponderating expulsive forces. This is due to fixation of the injured parts to the corresponding side of the pelvis by inflammatory action; consequently a bloody operation can do nothing towards elevating the uterus when this form of laceration has occurred.

Next is a consideration of the preparatory treatment which precedes the bloody operations described, especially those for retroversion and prolapsus. In his second paper Dr.

Emmet attaches so much importance to the preparatory treatment for the bloody operation that he recommends its continuance from one to three months.

There is no doubt that his estimate of the importance of this item of practice is correct, and that its observance is essential to whatsoever success can be legitimately claimed for his bloody operation. But can it be truthfully said that large hot-water injections, astringents applied to the walls of the vagina, air distended elastic and ring pessaries, are sufficient to fulfill all the indications? Will they under the most favorable circumstances, even when supplemented by his bloody procedure, ever secure the fullest measure of success which can be obtained by a different form and by mechanical treatment alone? I think not, and for two reasons: —

First. Because both walls of the vagina, the sacro-uterine ligaments, and to a greater or less extent the broad ligaments, each the seat of an important counteracting force, are weakened, relaxed, and more or less stretched by the gradually increased tension which the expulsive forces have produced.

Second. Because all ring-shaped pessaries, of whatsoever material made, tend to still further stretch the walls of the vagina, and in that manner favor the descent of the heavy uterus into the pelvic cavity. The vaginal douches and the astringent applications, in themselves, possess unquestionable utility, but their action is only temporary so long as the expulsive forces preponderate. This preponderance certainly will continue indefinitely unless this state of affairs can be reversed, and the expulsive, for a time at least, be made subordinate to the counteracting forces. But it may with propriety be asked how is this problem in mechanics to be solved? This is a question which has engaged my attention for more than a quarter of a century, and I dare say others have given thought to the same subject. Only a brief outline, however, of my labor in this direction can be given in this paper. Suffice it to say: —

First. To aid in accomplishing what is desired, the knee-

elbow or knee-chest position is of the greatest importance. When the patient is placed in this position we have the most complete extension of the vertebral column possible, the highest degree of relaxation of the diaphragm, and the abdominal muscles; and at the same time the pelvic and abdominal viscera fall forwards.

Second. The vagina must be distended to its fullest extent by the admission of air and the use of a suitable speculum.

Third. There must be formed a firm pyramidal column of carbolized cotton or wool extending from the posterior vaginal cul-de-sac obliquely downwards across the axis of the vagina to a point just within the pubic arch, and the range of the perineum.

By this mode of procedure it can be seen that, for the time being at least, the abdominal or expulsive forces are made to operate only at the greatest mechanical disadvantage; in other words, their action is reduced to the minimum degree.

The uterus, the bladder, and the rectum are thus made to gravitate beyond healthy limits, and so give the most perfect relief to all the structures in which the counteracting forces reside. The flattened column of cotton thus constructed, with its base upwards, is in a position to support, not only the uterus and the walls of the vagina, but also the ovaries, which are so frequently prolapsed in these cases.

The flattening of the column of cotton is intended also to save the rectum and bladder from undue pressure, such as may interfere with their functions. The narrowness of the column of cotton is also to be observed in order that the lateral walls of the vagina may not be distended, but rather encouraged to contract.

The pieces of cotton or wool with which the column is formed, may be secured in loops of strong sewing thread so that the patient can remove them at the end of two or three days, and take the vaginal douche of warm water, preparatory to a renewal of the procedure. When the above indications are all fulfilled, the woman assumes the position

upon her feet, and goes about her daily business, whatever this may be.

The *modus operandi* of this mechanical method of treatment, whether called *preparatory* or *curative*, is I think, simple, and one which can be easily understood by the patient. The latter is a fact of no small importance.

There are, however, objections to this plan of treatment.

First. On the score of time and attention on the part of the physician to carry it out.

Second. The prejudice of the physician and of the patient may be against the knee-elbow position.

Third. There is a defectiveness in the specula ordinarily employed.

Fourth. The pessaries in common use do not have the proper shape to give the required support after the preparatory treatment.

The objections here enumerated I have endeavored to overcome, and I think I have succeeded in securing results which are equal, if not superior, in value to any now known by me, or obtained by any other method of treatment whether bloody or otherwise.

I know of no one either at home or abroad who has labored more earnestly to popularize the knee-elbow position in the profession, and to utilize it to the highest aims of science than myself. I feel quite certain that, at no distant day, gynecologists at least will come to appreciate fully its superior advantages, especially in the treatment of injuries of the bladder, of the vagina, and of retroflexion with fixation of the uterus.

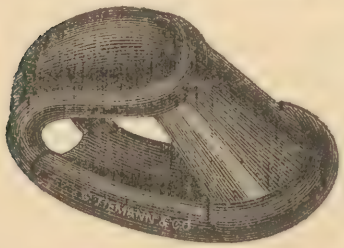
With reference to my own instruments, nearly all of them are constructed with the view of securing the greatest advantage to be derived from this position.

I may be pardoned for saying that I have obtained most satisfactory results by their use in the treatment of vaginal atresia and vaginal fistulæ of all varieties; and am now no less successful than I have been during the past ten years in securing favorable results in the treatment of retroversion and prolapsus of the uterus. I have labored long to

devise a suitable vaginal support to take the place of the column of carbolized cotton, but it is only within the last year that I have succeeded in bringing the instrument to a degree of perfection which enables me to predict its ultimate success.

This instrument is constructed upon the principle of the parallelogram.

It is elastic and thoroughly self-sustaining.[1] The instrument is made of coiled steel wire. It has vesical and rectal branches which are covered with thin rubber up to points near the heel of the instrument, where an opening is left for the escape of the menstrual and other discharges.



Upon the vesical branch is set a hair cushion which is to receive and support the vesico-vaginal septum. The covering of the rectal branch is distended with air in order that it may adapt itself uniformly to the recto-vaginal septum. The two upper uneven points are united by a broad elastic apron which, like a chair, is to receive the cervix uteri, and to a certain extent support the weight of the entire organ. When viewed edgewise the instrument presents somewhat the appearance of a jockey's cap, and a medical friend suggested that it should be called the "jockey-cap" pessary. However, to avoid the name of a uterine pessary, I prefer to call it a *vaginal support*. This name is in strict accord with the action of the instrument, for it leaves the uterus and its relaxed ligaments to take care of themselves in their normal relation and position. This is an attainment of the highest aim I can conceive for any form of instrument employed for the latter purpose.

This instrument is not only useful for maintaining the uterus in an elevated position after retroversion and prolapsus has occurred, but it is also a most valuable instrument with which to accomplish the same end after the

[1] See Figure showing the largest size, No. 3, and reduced one-half.

retroflexed and fixed uterus has been dislodged from the hollow of the sacrum by means of the cotton columns or compresses already described.

After proper preparatory treatment by means of the cotton columns directed obliquely against the vesico-vaginal septum from the perineum or *point d'appui*, the instrument can be used with equally satisfactory results in cases of anteflexion and anteversion of the uterus.

I have numerous illustrations which show in what direction the several forces alluded to operate, both with reference to the oblique cotton columns employed in the preparatory treatment, and the vaginal support used in the curative treatment, but time and space do not permit their description and introduction into the present paper.

Suffice it to say that retroflexion and fixation of the uterus in the hollow of the sacrum, constitute, both in the primiparæ and in the multiparæ, the largest class of uterine displacements, and often the most deplorable, which we are called upon to treat. Hitherto, treatment of these cases by means of the uterine sound and stem pessary has been unsatisfactory, and, according to my experience, a more comfortable, safe, and effective method is unquestionably a great desideratum. The plan of treatment which I have described is nothing more nor less than an application of some of the principles of orthopedic surgery to uterine distortions, and, I think, will accomplish the end desired.

Since I first adopted this plan of treatment, now nearly seven years ago, I have relieved a number of most unpromising cases, such I am sure as could not have been cured by the use of the uterine sound and the stem pessary. These were cases in which one or both ovaries were imprisoned and unduly compressed, chiefly by the supplementing force residing in the rectum. These are the cases which more frequently than any others suggest the performance of the bloody operation of normal ovariotomy first proposed a few years ago by Dr. Robert Battey, of Georgia.

A large proportion of cases which have entered my service at the Woman's Hospital, of the State of New York,

since I went on duty in March last, have belonged to this class. They have been treated by the plan here indicated, and with the most satisfactory results.

The history of several cases which fully illustrate my views as set forth in this paper, could be given, but owing to the length of the present article that must be deferred until some future date.

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III. Extirpation of the Functionally Active Ovaries for the Remedy of otherwise Incurable Diseases. By Robert Battey, Rome, Ga.

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